PROVIDER AGREEMENT – Group Provider - Member Update

State Form 51405 (7-03)
Indiana State Department of Health

Provider Name: _____

Provider Number: _____ Taxpayer Identification Number: _____

Contact Name: _____ Phone Number: _____

Return Address: _____

City, State, Zip code: _____

Please update the provider participation information for our group.

I certify, under penalty of law, that the information stated in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Indiana State Department of Health Programs and/or prosecution for Fraud. I hereby authorize the Indiana State Department of Health to make all necessary verifications concerning me, and this medical practice and further authorize and request each educational institution, medical/license board, or organization to provide all information that may be sought in connection with my/our participation in the Indiana State Department of Health Programs.

Group Provider Officer's Printed Name: _____

Officer's Title: _____

Officer's Signature: _____ Date:_____

Officer's Telephone Number: _____

Service Location Links

Group Provider - Member Update

Transaction Types: A = Add practitioner to service location
E = End-date practitioner from service location
U = Update information for practitioner at service location

Transaction Type	Effective Date	Expiration Date	Provider Type	
___	__________	__________	______	**Provider Name:** ____
				Specialty: ____
	__________	__________		**License/Registration/Certificate Number:** ___________________________
	__________	__________		**Federal DEA Certificate Number:** __________________________________
___	__________	__________	______	**Provider Name:** ____
				Specialty: ____
	__________	__________		**License/Registration/Certificate Number:** ___________________________
	__________	__________		**Federal DEA Certificate Number:** __________________________________
___	__________	__________	______	**Provider Name:** ____
				Specialty: ____
	__________	__________		**License/Registration/Certificate Number:** ___________________________
	__________	__________		**Federal DEA Certificate Number:** __________________________________
___	__________	__________	______	**Provider Name:** ____
				Specialty: ____
	__________	__________		**License/Registration/Certificate Number:** ___________________________
	__________	__________		**Federal DEA Certificate Number:** __________________________________
___	__________	__________	______	**Provider Name:** ____
				Specialty: ____
	__________	__________		**License/Registration/Certificate Number:** ___________________________
	__________	__________		**Federal DEA Certificate Number:** __________________________________